

Major Depression and Borderline Personality Disorder Are Misdiagnosed in Transgender Clients with Gender Dysphoria



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Abstract

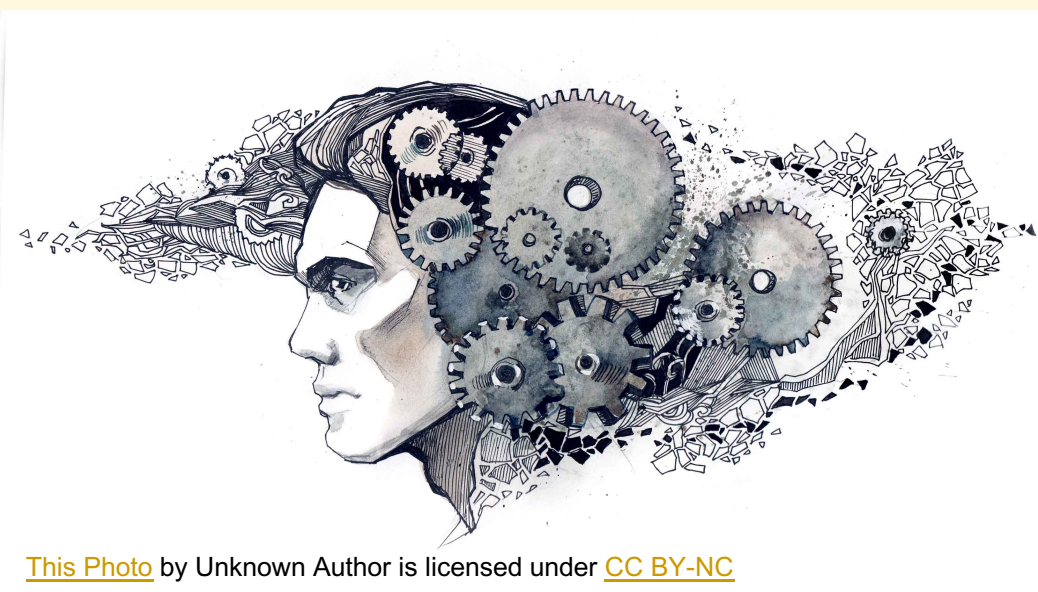
Overdiagnosis of Borderline Personality Disorder (BPD) was evaluated in this vignette study with a fictional client with Gender Dysphoria (GD) and several BPD symptoms. GD was most commonly diagnosed, followed by major depression, then BPD. Clinicians’ baseline transphobia, comfort, and personal experience with transgender people differed depending on diagnosis assigned.

Introduction

- ❖ Transgender and gender diverse (TGD) individuals often receive pathologizing diagnoses, potentially due to transphobia and lack of trans-affirmative training.
- ❖ Emerging evidence suggests that Borderline Personality Disorder (BPD) is particularly over-diagnosed among TGD individuals, leading to ineffective treatment and stigma.
- ❖ Over-diagnosis of BPD can exacerbate issues such as increased self-harm behaviors and withdrawal from treatment.
- ❖ The aim of our study was to investigate the anecdotal overdiagnosis of BPD among TGD individuals and identify contributing factors and rationales behind this misdiagnosis.

Research Gap

- ❖ No research has examined the anecdotal overdiagnosis of BPD and identified the factors and rationales that contribute to overdiagnosis or misdiagnosis.
- ❖ Our research fills this gap by examining practitioner diagnoses in a fictional vignette study.



Hypotheses

- ❖ H1: BPD will be the most frequently assigned diagnosis in a case presenting an individual meeting criteria for gender dysphoria.
- ❖ H2: Among those who misdiagnose BPD, diagnostic features other than gender identity concerns will be rated as most salient in diagnostic decision-making.
- ❖ H3: Mental health providers who have training with TGD groups will be more likely to diagnose gender dysphoria than BPD (or another diagnosis) than mental health providers who do not have any training with TGD groups.
- ❖ H4: Transphobic attitudes will predict a diagnosis of BPD in the case vignette.

Methodology: Participants

- ❖ Participants included 178 currently practicing mental healthcare providers.
- ❖ Participants were recruited through several APA Division members email listservs via a single-stage sampling model.

Methodology: Case Vignette

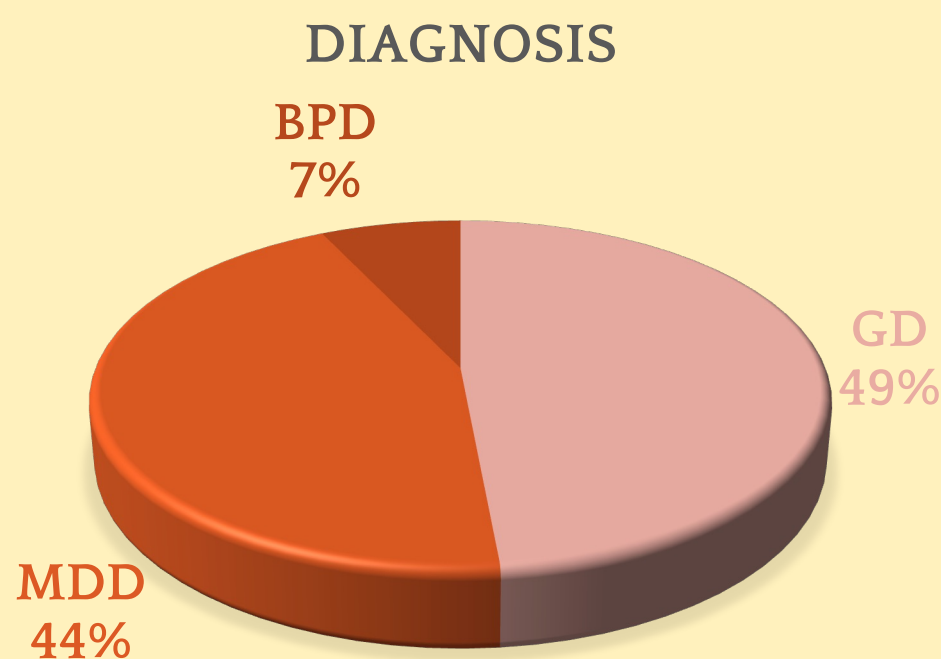
- ❖ An original case vignette was presented to participants and included demographic information of a client presenting with suicidal ideation, school avoidance, and gender identity concerns.
- ❖ The vignette reflected the common overlapping symptomology associated with BPD and gender dysphoria that may confound diagnostic decision-making.

Methodology: Diagnostic Questionnaire

- ❖ A diagnostic questionnaire following the case vignette was developed for the purposes of our study.
- ❖ Participants were asked to select a diagnosis from a list which included GD and BPD, as well as an option to provide an alternative diagnosis following the case vignette.

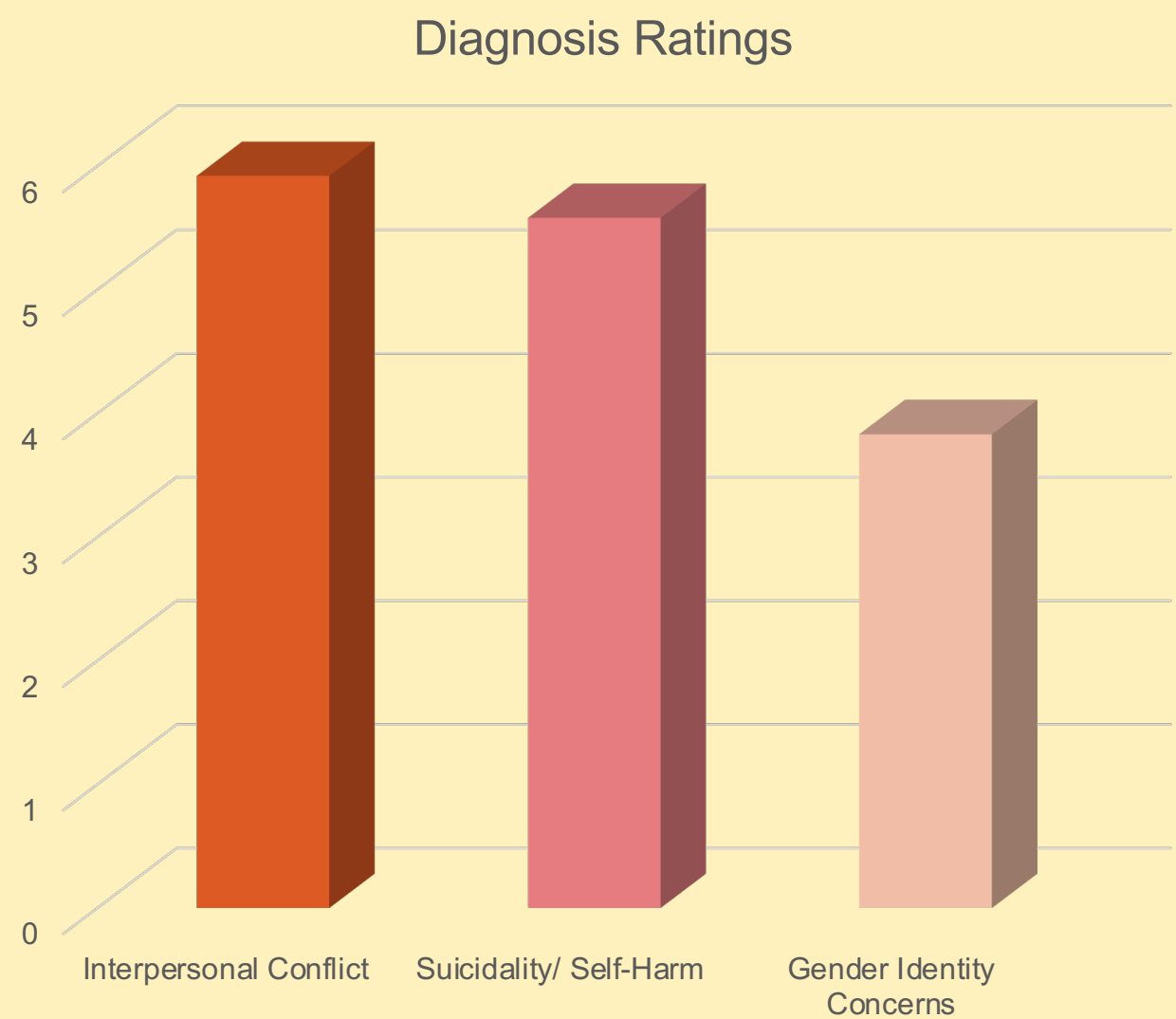
Results: Diagnosis

- ❖ BPD was the third most diagnosed disorder ($n = 12$; 6.9%), with gender dysphoria ($n = 82$; 46.9%) and major depressive disorder ($n = 75$; 42.9%) accounting for the majority of diagnoses.



Results: Diagnosis Ratings

- ❖ Those who were diagnosed with BPD rated interpersonal conflict ($M = 5.92$; $SD = .90$), and suicidality and self-harm behaviors ($M = 5.58$; $SD = 1.24$) as significantly more influential in their diagnosis than gender identity concerns ($M = 3.83$; $SD = 2.08$).



Results: Continued

- ❖ Clinician background in areas such as personal knowledge of TGD-related issues [$t(173) = 3.59$, $p = <.001$], level of transphobia [$t(173) = 2.40$, $p = .017$], and personal comfort working with TGD groups [$t(173) = 3.12$, $p = .002$], were significantly different across choice of primary diagnosis.
- ❖ Participants who diagnosed gender dysphoria demonstrated the following: higher transphobia levels, less personal knowledge of TGD-related issues, and less personal comfort with TGD communities.
- ❖ Training and experience working with TGD groups were not significantly related to the diagnostic group ($p > .05$).

Discussion

- ❖ Findings suggest diagnosticians prioritize outcomes of minority stress related to gender dysphoria (e.g., depressed mood, conflict, self-harm) over diagnosing gender dysphoria itself.
- ❖ Misdiagnoses may impede gender-affirming care or therapy targeting gender dysphoria symptoms.
- ❖ Trans-affirmative diagnosticians might hesitate to diagnose Gender Dysphoria to avoid pathologizing TGD individuals.
- ❖ Future research can investigate how levels of transphobia among clinicians influence diagnostic decision-making in TGD groups.

References

